AIDS CASE MANAGEMENT PROGRAM (CMP)
INFORMED CONSENT/AGREEMENT TO PARTICIPATE

APPLICANT'S NAME: Chart Number:

I have been informed of services of the AIDS Case Management Program (CMP). I understand that as part of my application for services under the CMP, the Nurse Case Manager and Social Work Case Manager must evaluate my condition. My Nurse Case Manager and Social Work Case Manager will coordinate the care I receive at home. I understand that:

1. I will participate in the process for deciding the services that I will receive and will be notified of what services I am to receive and any subsequent changes made to these services. These services will be based on need and availability of funding. The CMP is constructed so that I will incur no cost as a result of my participation. However, the CMP monies will be the last source of payment to provide services; if care is available through another entity, e.g., insurance policy, then that source will be billed before the CMP program.

2. The Nurse Case Manager and Social Work Case Manager will keep track of my progress and will develop a personalized service plan. The types and quantities of services will be determined through regular meetings with me and interdisciplinary team meetings.

3. I will be asked to provide personal information about myself including name, race, gender, health, and other pertinent information. No identifying information collected will be used against me or will be released without my consent, except as allowed by law. However, summary data based on CMP participants (*personal identifiers deleted*) may be used for research and publication. A certificate of confidentiality is in place that specifies that researchers keep client information confidential. The CMP is committed to maintaining the highest possible level of confidentiality.

4. Information from my case record will be seen only by approved staff, consultants, and service providers, who will be serving me, or as otherwise provided by law. I understand that my case may be discussed at regular case conferences, consisting of CMP staff, my physician and contractors supplying direct care services to me.

5. My participation in the CMP is entirely voluntary and I may decide to withdraw at any time and there will be no penalties or loss of other services I am entitled to. My withdrawal will not affect the availability of medical care to me at any time. Furthermore, my doctor may withdraw me from the CMP at any time if it's in my best interest to do so.

6. I understand that I must meet all CMP eligibility requirements, including medical needs and condition, and that if I am hospitalized I will not receive CMP services until my discharge. If I am hospitalized for more than 30 days, I will be disenrolled from the CMP. I also understand that I must comply with CMP program requirements as explained to me at enrollment.

7. I agree to cooperate fully with Agency/CMP staff and care providers and agree to refrain from any verbal or physical hostile, abusive, or threatening behavior. I understand that failure to comply with this provision may result in termination of services.

8. I have the right to ask any questions concerning the CMP at any time. I will be informed of any significant new information pertinent to my participation. If I have any questions concerning the CMP program, I may contact my Nurse Case Manager or Social Work Case Manager.

9. I understand that CMP staff are mandated reporters. I also understand that as mandated reporters they have to report situations such as elder or dependent abuse, child abuse, suicidal ideations, or homicidal ideations. The reasoning for such reports, as well as examples of such instances, has been explained to me.

10. Client Initials_____I acknowledge that I have received a copy of the Agency Grievance Policy.

    Client initials_____I acknowledge that I have received a copy of the Client Rights.

I have read and I understand the above information concerning the program. My signature indicates my agreement to participate in the program. I will be given a copy of this consent form to refer to as needed.

All questions I have concerning the CMP at this time have been fully answered. If I have further questions, I should contact the CMP Staff at:_____

Applicant's Signature: Date

Agency Representative: Date: